STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155377	B. WING		05/25/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	CR.		JACKSON PARK DR	
SEYMOU	JR CROSSING			OUR, IN 47274	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Recertification and	F0000	PREPARATION AND/OR	
			10000	EXECUTION OF THIS PLAN	OF.
	State Licensure	Survey.		CORRECTION IN GENERAL,	
				OR THIS CORRECTIVE ACTI	
	Survey dates: N	May 21, 22, 23, 24, and 25,		IN PARTICULAR, DOES NOT	-
	2012			CONSTITUTE AN ADMISSIO	
				OR AGREEMENT BY THIS	
	Facility number	000272		FACILITY OF THE FACTS	
	Provider number			ALLEGED OR CONCLUSION	S
				SET FORTH IN THIS	
	AIM number: 1	1002/4/10		STATEMENT OF DEFICIENCIES. The plan of	
	Survey team:			correction and specific	
	Jill Ross, RN-T	C		corrective actions are prepar	red
	1			and/or executed in complian	
	-	RN (May 21, 22, and 23,		with state and federal laws.	
	2012)			The facility is requesting a	
	Diana Sidell, Rl	N		DESK REVIEW of complianc	e
	Cheryl Fielden,	RN		for this plan of correction.	
	Census bed type	2:			
	SNF/NF: 73				
	Total: 73				
	10111. 73				
	Census payor ty	pe:			
	Medicare: 7	-			
	Medicaid: 61				
	Other: 5				
	Total: 73				
	Sample: 15				
	Supplemental sa	ample: 2			
	Supplemental So	ampie. Z			
	These deficienc	ies also reflect state			
	findings cited in	accordance with 410 IAC			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000272

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155377	A. BUILDING  B. WING	00	COMPLETED 05/25/2012
	PROVIDER OR SUPPLIEF JR CROSSING	R	707 S J	ADDRESS, CITY, STATE, ZIP CODE IACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	16.2.  Quality review of Jennie Bartelt, R	ompleted 6/4/12 by N.			

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Event ID: T9N511

Facility ID: 000272

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JETIPLE CO	DNSTRUCTION	(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00		
		155377	B. WIN			05/25/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOL	JR CROSSING				ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0279 SS=E	PLANS A facility must us assessment to do resident's compre.  The facility must care plan for each measurable object meet a resident's mental and psychidentified in the compression of the care plan must be furnished resident's highest mental, and psychedidentified under § that would otherwed where § 483.25 but are resident's exercisingluding the right § 483.10(b)(4).  Based on record facility failed to exercise the developed to meet individual needs plans failed to exercise the corresponded to the problems. The detail of 14 residents in a sample of 15 and #52). The detail affected 1 of 2 resident's compression of 15 and #52). The detail affected 1 of 2 residents in a facility failed to 2 residents in a facility failed to 3 of 14 residents in a facility failed to 4 affected 1 of 2 residents facility failed 1 affected 1 of 2 residents facility failed 1 affected 1 of 2 residents facility failed 1 affected 1 affected 1 affected 1 affected 1 affected 1 aff	the the results of the evelop, review and revise the ehensive plan of care.  develop a comprehensive the resident that includes ctives and timetables to a medical, nursing, and hosocial needs that are comprehensive assessment.  Lust describe the services that ed to attain or maintain the att practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, at to refuse treatment under review and interview, the censure care plans were	F02	79	F-279 COMPREHENSIVE CARE PLANS  A. ACTIONS TAKEN:  1. Resident #20,38,52 and 34 care plans reviewed and approaches revised to ensure that they correspond to the residents identified problems.		06/24/2012

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Event ID: T9N511

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED	
		155377	B. WIN	NG		05/25/2012	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					IACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP			
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Findings include	:			D. OTHERS IDENTIFIED.		
					B. OTHERS IDENTIFIED:		
	1. The clinical re	ecord for Resident #20					
	was reviewed on	5/21/12 at 1:37 p.m.					
					1. All other residents have the		
	In the care plan s	section of the record, each			potential to be affected.		
	of the resident's	care plans had columns					
		goal, approach, and			2. 100% audit of all residents		
	discipline. Each				care plans to ensure that		
	•	ms was listed on a			approaches indicated correspond to identified problems to be complete		
	separate care pla				by IDT team by 6/24/12.	u	
		ed to providing care for			2, 12.1 (64.11 2, 6, 2.1, 12.1		
	that problem.	ed to providing care for					
	that problem.						
	Dagidant #201a as	one plane indicated:			C. MEASURES TAKEN:		
	Resident #20 8 Ca	are plans indicated:					
	Duahlama "Daaid	ant has Dr. (diamasis).					
		ent has Dx (diagnosis):			All Licensed Staff were		
		ficiency," with a start					
		nd a goal target date of			in-serviced on Care Plan		
	* *	ches indicated, "Labs as			development and revision in regard	ls	
		nedication] as ordered,			to establishing approaches that		
	- '	or) and family of any			correspond to the residents'		
	status changes ar	nd PRN (as needed)"			identified problems by DNS/ designee on 6/12/12.		
					Georginee on 0/12/12.		
	The same inform	nation was listed on care			2. The IDT will review/revise		
	plans with proble	ems, based on the			resident care plans after quarterly		
	resident's diagno	ses, as follows.			assessment, and prn, and during the	e	
					care plan conference with the		
	"Resident has Dx	x: Obesity" with a start			resident/ family to ensure that care		
		nd a goal target date of			plans are individualized and meet	u	
		ches indicated, "Labs as			individual needs and goals. This will	11	
		s ordered, Notify MD and			be an on-going QA program.		
	=	tus changes and PRN."			3. The DON/Designee will		
	Talling Of ally Sta	ias changes and 1 1014.			review/revise resident care plans		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	BUILDING 00		COMPLETED	
		155377	B. WIN			05/25/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			IACKSON PARK DR		
SEYMOL	JR CROSSING				OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
		x: Ventral Hernias x 2 3			with new orders and change of		
	` ′	" with a start date of			condition.		
	4/25/12 and a go	al target date of 7/25/12.					
	Approaches indi	cated, "Labs as ordered,					
	Meds as ordered	, Notify MD and family			D. HOW MONITORED:		
	of any status cha	inges and PRN."					
		8					
	"Resident has D	x: Zinc deficiency" with a					
		5/12 and a goal target date			1. To ensure compliance, the		
		0 0			DNS/ Designee is responsible for the	e	
		roaches indicated, "Labs			completion of the Care Plan		
	•	s as ordered, Notify MD			Updating CQI tool weekly times 4		
		y status changes and			weeks, bi-monthly times 2 months, and then quarterly until continued		
	PRN."				compliance is maintained for 2		
					consecutive quarters. The results o	f	
	"Resident has D	x: Mental Retardation"			these audits will be reviewed by the		
	with a start date	of 4/17/12 and a goal			CQI committee overseen by the ED.		
	target date of 7/1	7/12, "Resident has Dx:			If threshold of 95% is not achieved		
	Hypothyroidism	" with a start date of			an action plan will be developed to		
	4/25/12 and a go	al target date of 7/25/12.			ensure compliance.		
	_	cated, "Labs as ordered,					
		, Notify MD and family					
	of any status cha	•			E. This plan of correction		
	Status Cha	mgeo una i ia i.			constitutes our credible allegation		
	"Resident has D	v. Hyparlinidamia" with a			of compliance with all regulatory		
		x: Hyperlipidemia" with a			requirements, out date of		
		5/12 and a goal target date			completion is:		
		roaches indicated, "Labs					
	· ·	s as ordered, Notify MD			6/24/12.		
		y status changes and					
	PRN."						
	"Resident has Da	x: Moderate Psychosis"					
	with a start date	of 4/17/12 and a goal					
		7/12. Approaches					
		as ordered, Meds as					

A. BUILDING	PLETED
155377 B. WING 05/2	5/2012
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
707 S JACKSON PARK DR	
SEYMOUR CROSSING SEYMOUR, IN 47274	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR USC IDENTIFYING INFORMATION)  TAG	COMPLETION
TAG REGULATORI OR ESCI DESTITI TING INCOMPATION)	DATE
ordered, Notify MD and family of any	
status changes and PRN."	
"Resident has Dx: Major Depression with	
Psychosis" with a start date of 4/17/12	
and a goal target date of 7/17/12.	
Approaches indicated, "Labs as ordered,	
Meds as ordered, Notify MD and family	
of any status changes and PRN."	
"Resident has Dx: Abdominal Pain" with	
a start date of 4/17/12 and a goal target	
date of 7/17/12. Approaches indicated,	
"Labs as ordered, Meds as ordered, Notify	
MD and family of any status changes and	
PRN."	
"Resident has Dx: HTN" (high blood	
pressure) with a start date of 4/17/12 and	
a goal target date of 7/17/12.	
Approaches indicated, "Labs as ordered,	
Meds as ordered, Notify MD and family	
of any status changes and PRN."	
of any status changes and rich.	
2. The clinical record was reviewed for	
Resident #38 for care plans on 5/22/12 at	
9:30 a.m.	
In the care plan section of the record, each	
of the resident's care plans had columns	
titled: problem, goal, approach, and	
discipline. Each of the resident's	
identified problems was listed on a	
separate care plan and included	

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Event ID: T9N511

Facility ID: 000272

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		LDING	NSTRUCTION 00	(X3) DATE COMPL 05/25	ETED	
	PROVIDER OR SUPPLIER		707 S J	ACKSON PARK DR UR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	information relat that problem.	ed to providing care for				
	Resident #38's ca	are plans indicated:				
	Problems:					
		agnosis of Vitamin B 1 a date of 3/15/11 and a of 6/7/12;				
		x: Nausea and vomiting" 15/11 and a goal target				
		x: Tremors"with a start nd a goal target date of				
		c: Osteoporosis" with a 1/2011 and a goal target				
		art date of 11/14/11 and a of 6/7/12;				
		x: History of DVT (blood 11 with a goal target date				
	respiratory failur	x: History of acute re with a date of 4/6/11 date of 12/29/12.				

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE ( COMPL		
		155377	A. BUI B. WIN	LDING		05/25/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	LSC IDENTIF TING INFORMATION)		IAG			DATE
	Approaches for 6	each of care plans above					
		rdered, Meds as ordered,					
		Camily of any status					
	changes and PRI						
		ressure Wound Skin					
		rt for Resident #38,					
		/12 at 9:03 a.m., from the					
	_	, indicated this resident					
		wound on 12/1/11, and					
	_	indicate it healed until					
		e plan with a start date of ed there was a "Problem:					
		breakdown" but did not					
	_	dent actually had an					
		wound. No changes or					
		care plan for skin					
		made the Approaches to					
	care. No other c	are plans for this resident					
	addressed wound	ls of any kind.					
		ecord for Resident #52					
	was reviewed on	5/23/12 at 10:20 a.m.					
	In the same with	vaction of the manual and					
	_	section of the record, each care plans had columns					
		goal, approach, and					
	discipline. Each						
		ms was listed on a					
	separate care pla						
		ed to providing care for					
	that problem.	r					
	•						

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Event ID: T9N511

Facility ID: 000272

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377		LDING	NSTRUCTION  00	(X3) DATE COMPL 05/25/	ETED
	PROVIDER OR SUPPLIER		<b>.</b>	707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR PUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	"Resident has Day with a start date target date of 6/2  "Resident has Day hand" with a start goal target date of 10 (stroke) with a start goal target date of 10 (stroke) with a start date target date of 10 (low level of thy bloodstream) with a start date target date of 10 (low level of thy bloodstream) with a start date target date of 6/2  "Resident has Day with a start date target date of 6/2  "Resident has Day with a start date target date of 6/2  "Resident has Day with a start date target date of 6/2  "Resident has Day Failure" with a start date of 10 (start) with	a: Contracture to left at date of 3/21/12 and a of 6/21/12; a: Old right CVA" art date of 3/21/12 and a of 6/21/12; a: History of ow body temperature) of 3/21/12 and a goal a1/12; a: History of Myxedema" roid hormone in the a start date of 3/21/12 date of 6/21/12; a: History of pneumonia" of 3/21/12 and a goal a1/12; a: History of Respiratory tart date of 3/21/12 and a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155377	B. WIN	G		05/25/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	a goal target date	e of 6/21/12;					
	"Resident has Da	x: History of Recent					
	septic shock" wi	th a start date of 3/21/12					
	and a goal target	date of 6/21/12;					
	"Resident has Da	x: hypothyroidism" with a					
		/12 and a goal target date					
	of 6/21/12;	, 88					
	01 0/21/12,						
	"Resident has Da	x: Cervical stenosis with					
		h a start date of 3/21/12					
	1 2 1 2						
	and a goal target	date of 6/21/12,					
	WD :1 (1 D	II					
	"Resident has D	-					
		with a start date of					
	3/20/12 and a go	al target date of 6/20/12;					
	"Resident has D	x: Protein Malnutrition"					
	with a start date	of 3/21/12 and a goal					
	target date of 6/2	21/12.					
	Approaches for e	each of the above					
	problems were:	"Labs as ordered, Meds					
		y MD and family of any					
		nd PRN." There were no					
	_	s made on this care plan					
	for these problem	_					
	101 these problem	110.					
	1 The clinical r	ecord for Resident #34					
	was reviewed on	5/23/12 at 9:08 a.m.					
		. 1.11/10/11					
	_	ated 11/10/11, was as					
	follows:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155377	B. WING		05/25/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
SEAMOI	JR CROSSING			IACKSON PARK DR DUR, IN 47274	
				JUK, IN 47274	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
1110	REGUESTION	KESE IDENTIFICATION OR MICHAELING	1710		BALL
	Problems: "Sad	mood indicators noted			
		s evidence by Feeling			
	_	energy, Feeling hopeless			
	_	mily support/restlessness			
		x: Mood disorder,			
	1	order, Depression" with a			
		10/11 and a goal target			
		Approaches: "Enjoys			
		hers, TV, music, outdoors,			
	_	l events." The care plan			
	_	any change in the			
		ences. A plan of care			
	_	e on 4/18/2012, but no			
	_	ade according to the care			
	plan.	ade according to the care			
	pian.				
	In interview wit	h Resident #34 on 5/22/12			
		e indicated she does not			
	_	tivities any more. The			
		he "quit because they (the			
		boring." She also			
	· ·	e had done anything to			
	help or change t	, ,			
	noip of change t	ne activities.			
	In interview on	5/24/12 at 2:30 p.m., with			
		tor of Nursing Services),			
	· ·	e knew there was a			
		e care plans and they			
	_	orate Nurse) would work			
	on them.	orace range, would work			
	on them.				
	On 5/23/12 at 2	:00 p.m., the request was			
		licy and procedure on			
	induction the po-	ne, and procedure on			

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Event ID: T9N511

Facility ID: 000272

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155377	A. BUILDING  B. WING	00	COMPLETED 05/25/2012
	PROVIDER OR SUPPLIER  JR CROSSING	707 S JA	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR JR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	implementing care plans. On 5/25/12 at 8:30 a.m., another copy was requested. A policy was received on 5/25/12 at 12:38 p.m., from the DNS and was titled "Care Plan Guidelines." Review of the policy indicated a guide for care plan meetings with families and residents. It did not give guidelines for developing and implementing care plans. No other policy and procedure was provided for care plans. The DNS stated, "This is all we have."  3.1-35(a) 3.1-35(b)(1)			

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Facility ID: 000272

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMPI	LETED	
		155377	B. WIN	G		05/25	/2012
	ROVIDER OR SUPPLIER			707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	MAIL	DATE
F0334 SS=D	483.25(n) INFLUENZA AN IMMUNIZATION The facility must procedures that (i) Before offering each resident, or representative re the benefits and immunization; (ii) Each resident immunization Oc annually, unless medically contra already been immunization; (iii) The resident representative ha immunization; ar (iv) The resident documentation th the following: (A) That the res representative w regarding the be effects of influen (B) That the res influenza immun influenza immun contraindications  The facility must procedures that (i) Before offering immunization, ea legal representati regarding the be effects of the immunization, ur immunization, ur	D PNEUMOCOCAL S develop policies and ensure that g the influenza immunization, the resident's legal eceives education regarding potential side effects of the t is offered an influenza etober 1 through March 31 the immunization is indicated or the resident has munized during this time  or the resident's legal as the opportunity to refuse and indicates, at a minimum, sident or resident's legal as provided education nefits and potential side za immunization; and sident either received the ization or did not receive the ization due to medical s or refusal.  develop policies and ensure that g the pneumococcal ach resident, or the resident's tive receives education nefits and potential side munization; t is offered a pneumococcal aless the immunization is indicated or the resident has		TAG	DEFICIENCY)	NOTE.	DATE
	,	,					

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Event ID: T9N511

Facility ID: 000272

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/25/2012
	ROVIDER OR SUPPLIEF		707 S .	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	(iii) The resident representative himmunization; ar (iv) The resident documentation to the following:  (A) That the resident documentation to the following:  (A) That the resident was regarding the been effects of pneum (B) That the resident documentative was regarding the present of the pneumococcal in receive medical contral assessment and recommendation immunization may following the first immunization, uncontraindicated or resident's legal resecond immunization. This after eviewed for pneumococcal in the first immunizations in of 2. (Resident #Findings included The clinical recorreviewed on 5/23.  The MDS (Mining assessment, date	or the resident's legal as the opportunity to refuse and as the opportunity to refuse and as medical record includes that indicated, at a minimum, sident or resident's legal as provided education nefits and potential side accoccal immunization; and sident either received the munization or did not amococcal immunization due aindication or refusal. Itive, based on an practitioner and as econd pneumococcal and be given after 5 years to pneumococcal and the resident or the epresentative refuses the ation.  The review and interview, the give the pneumonia affected 1 of 2 residents the end of the preumonia and the preumoni	F0334	F-334 Influenza and pneumococcal immunizations  A. ACTIONS TAKEN:  1. Resident #34 was given the pneumonia vaccine on 5/24/12.  B. OTHERS IDENTIFIED:	06/24/2012

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Event ID: T9N511

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155377	B. WIN			05/25/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			IACKSON PARK DR		
SEVMOI	JR CROSSING				OUR, IN 47274		
SETIVIOC	JK CKOSSING			SETIVIC	JOK, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	vaccine offered a	and declined.					
					1. All other residents have the		
	The signature na	ge for the pneumococcal			potential to be affected.		
		ated 10/20/11, had the					
		•			2. 100% audit of all residents		
	resident's signatu	_			pneumonia vaccination consent		
		ne facility to administer			form to be completed by IDT team		
	the Pneumococc	al Vaccination.			by 6/24/12.		
	In interview on 5	5/24/12 at 8:45 a.m., the					
		indicated, "The resident					
	_	· ·			C. MEASURES TAKEN:		
		pneumonia vaccine in					
	2009. We didn't	see the informed consent					
	form signed 10/2	20/11. We tried to look			All Licensed Staff were		
	on the MARS (n	nedication administration			1. All Licensed Staff were		
	records) and TA	RS (treatment			in-serviced on the facility		
	· · · · · · · · · · · · · · · · · · ·	ecords) and can't find			pneumococcal policy and procedure	۵	
		<i>'</i>			and provision of the pneumonia		
		en. We are going to give			vaccine according to pneumonia		
	it now."				vaccination consent form by the		
					DNS/ designee on 6/12/12.		
	The Resident Im	munization and Health					
	History Form an	d the TAR received			2. The IDT will review new		
	1 -	ı.m., from the Director of			admissions for completion of the		
		s, had a date of 5/24/12			pneumonia vaccination consent		
	_				form and to ensure vaccination is		
	for the pneumon	ia vaccine given.			administered.		
	3.1-13(a)						
					D. HOW MONITORED:		
					1. To ensure compliance, the		
					DNS/ Designee is responsible for the	9	
					completion of the Pneumonia		
					Vaccination CQI tool weekly times 4		

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Event ID: T9N511

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155377	A. BUILDING  B. WING	00	COMPLETED 05/25/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
SEYMOU	IR CROSSING			JACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.  E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:  6/24/12.	

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Event ID: T9N511

Facility ID: 000272

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED
		155377	B. WING		05/25/2012
	ROVIDER OR SUPPLIER		STREET 707 S	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR OUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION COI SPREAD, LINEN The facility must Infection Control provide a safe, s environment and development and and infection.  (a) Infection Con The facility must	NTROL, PREVENT US establish and maintain an Program designed to anitary and comfortable to help prevent the d transmission of disease  trol Program establish an Infection	IAU		DATE
	infections in the (2) Decides what isolation, should resident; and (3) Maintains a recorrective action	controls, and prevents facility; t procedures, such as be applied to an individual ecord of incidents and s related to infections.			
	(1) When the Information (1) When the Information (1) The spreamust isolate the (2) The facility modern communicable dolesions from direct their food, if direct disease. (3) The facility modern communication (1) The facility modern communication (2) The facility modern communication (3) The facili	ust prohibit employees with a isease or infected skin ct contact with residents or ct contact will transmit the ust require staff to wash their direct resident contact for ning is indicated by accepted			
	transport linens so of infection.	handle, store, process and so as to prevent the spread ord review and interview,	F0441	F-441 Resident Records-	06/24/2012
	the facility failed	to ensure PPD/TB		complete/ accurate/ accessit	ole

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Event ID: T9N511

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  O	COMPLETED	
155377 B. WING	05/25/2012	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER  707 S JACKSON PARK DR		
SEYMOUR CROSSING SEYMOUR, IN 47274		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (FACH DEFICIENCY MUST BE DERCEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE		
TAG REGULATORY OF ESCHELING THOUGH ON MATTERY	DATE	
(tuberculosis) testing was performed in a  A. ACTIONS TAKEN: 1.  Resident #19 has received a new #10	9\W	
timely manner, in that Resident #19  PPD/TB test cycle. Resident #4		
received one step of the two step PPD/TB not action required. 2. All	71	
test, and Resident #47 received the licensed staff were in-serviced of	on	
PPD/TB test late. This affected 2 of 15 wound care policy re standard		
residents reviewed related to screening for precautions, glove use, and		
tuberculosis in a sample of 15. (Pasident proper sanitizing of scissors on		
0/12/12. B. OTHERS		
is the first test of the first	ho	
residents have the potential to the Brased on observation record review affected by the alleged deficien		
practice 2 All licensed staff		
and interview, the facility failed to ensure were in-serviced on wound care	e	
a dressing change was provided using policy re standard precautions,		
standard precautions for sanitizing glove use, and proper sanitizing	l l	
scissors and handwashing/glove use. The of scissors on 6/12/12. 3. 100°	%	
deficient practice affected 1 of 2 residents audit of all residents PPD/TB te	est	
in a symplemental complete of 2 during 1 of		
#40) were in-serviced on wound care policy re standard precautions,		
glove use, and proper sanitizing		
Findings included:  Findings included:  of scissors by the DNS/ designed		
on 6/12/12. 2. All licensed staf	ff	
A.1 Resident #19's record was reviewed to complete skill check for		
on 5/21/12 at 10:30 a.m. The record Dressing Change, Glove Use		
indicated Resident #19 was admitted with completed by DNS/ Designee b	ру	
diagnoses that included, but were not 6/24/12. 3. 100% audit of all residents PPD/TB test completi	ion	
limited to, hypertension, chronic by IDT team by 6/24/12 any	1011	
current will have PPD / TR test		
hemiparesis. administered. 4. PPD/TB tests		
will be tracked in a calendar		
Admission to the facility was on 6/17/11. format at each nursing station.		
The resident received the first step  The calendar will be taken to day  The calendar	-	
PPD/TB test on 6/17/11. No other stand up meeting to ensure PP TB tests are administered timel		
notations regarding the second step  D. HOW MONITORED: 1.	y.	
PPD/TB test were found in the record.  To ensure compliance, the DNS		

AND BLAN OF CORRECT	TION	IDENTIFICATION NUMBER.				(X3) DATE SURVEY	
AND PLAN OF CORRECT	HON	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155377	B. WIN			05/25/2012	
			b. Wilt		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OF	R SUPPLIER				ACKSON PARK DR		
SEYMOUR CROSS	SING				DUR, IN 47274		
` '				ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH	H DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG REGUL	ATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
Interview of the Corpone step on 6/17/ test was  A.2. Reform 5/24/ indicated diagnosed limited to cancer at the cancer at the cancer at the DNS was given the DNS was given the corpone a.m. The "TST( consist of injection 1-3 week.")	w on 5/2 porate N p PPD/TE /11 and ti not give /12 at 8:2 d Reside es that in to, asthmath hypo from to the dent rece /13 test on 4 /14/27/12, w on 5/2 /15, indicate for two dent for the dent rece /15 test on 6 /16 test on 6 /17 test of 12 /17 test of 12 /18 test on 6	1/12 at 1:30 p.m., with urse indicated that the B test was administered he second step PPD/TB n.  47's record was reviewed 1:5 a.m. The record not #47 was admitted with cluded, but were not a, stage IV (4) ovarian thyroidism.  2 facility was on 4/11/12. Evived the first step 4/13/12 and the second with both tests reading 4/23 at 9:30 a.m., with ed that the PPD/TB test			Designee is responsible for the completion of the Resident Mantoux, and Infection Contro Review CQI tools weekly times weeks, bi-monthly times 2 months, and then quarterly uncontinued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the committee overseen by the ED threshold of 95% is not achiev an action plan will be developed to ensure compliance. E. T plan of correction constitutes our credible allegation of compliance with all regulator requirements, out date of completion is: 6/24/12.	CQI D. If ed his	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUI	LDING	00	COMPL 05/25/	
		155377	B. WIN			05/25/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOL	JR CROSSING				ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ID order, if resident has					
		ented negative Mantoux					
	(PPD) during the	preceding 12 months."					
	B1. RN #1 was	observed providing a					
	dressing change	to a leg wound for					
	Resident #40 on	5/24/12 at 2:15 p.m					
	Wearing gloves,	RN #1 used scissors to					
	cut off the soiled	dressing from the					
	wound. During i	interview at this time, the					
	resident indicated	d the wound began as					
	cellulitis (swellin	ng, weeping) to her lower					
	legs. She indicat	ted she developed a boil					
	on the right lowe	r leg as a result of the					
	cellulitis. She in	dicated the boil was					
	lanced (cut open)	) by a doctor, and she					
	was placed on an	antibiotic. The soiled					
	dressing was obs	erved to have an area 5					
	cm (centimeters)	in circumference (a					
	circle) of green, t	thick drainage. As the					
	old dressing was	removed, the wound					
	began to bleed, a	nd blood was dripping					
	on the floor. RN	#1 cleansed the draining					
	wound. Without	changing					
	~	nands, and without					
	_	ssors previously used to					
	-	ed dressing, RN #1					
		dressing, cutting the					
	_	eissors, and applied the					
	dressing to the w	ound.					
		the Director of Nursing					
		/12 at 8:06 a.m., she					
		ility did not have a					
	policy for scissor	and glove use during					

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

 OF CORRECTION	IDENTIFICATION NUMBER:  155377	A. BUILDING  B. WING			COMPLETED 05/25/2012	
ROVIDER OR SUPPLIER		D. WIN	STREET A	ACKSON PARK DR		
SUMMARY ST (EACH DEFICIENCE REGULATORY OR  wound care. Rev provided indicate gloving technique control - universa not indicate where a dressing change how to change gla were necessary, a regarding cleaning  On 5/31/12 at 4:3 website: http://woundconstrile_dressing_chate indicated, "Non-strile_dressing_chate indicated, "Non-strile_dressings need clean or sterile so soiled dressing, proper soiled	ratement of deficiencies cy must be perceded by full Lisc identifying information)  riew of the policies ed a policy on non-sterile e and one for infection al precautions which did in to change gloves during e. The policy indicated oves and when gloves and there was no mention ag scissors.  80 p.m., review of the sultant.com/files/Non_ste ange_Procedure.pdf sterile Dressing Change in dressing items on table. to be cut to size, use esissors9. Remove blace it in trash bag10. wash hands, apply new in wound with normal and cleanser14. Remove ds, apply new y wound dressing. should cover entire	A. BUII B. WIN	G STREET A 707 S J	DDRESS, CITY, STATE, ZIP CODE		(X5) COMPLETION DATE
RN #1 indicated scissors with alco saw no problem is	she "will clean the bhol." She indicated she in the way she did the She indicated, "That's					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  05/25/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR	
SEYMOU	JR CROSSING			OUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-18(b)(2) 3.1-18(e) 3.1-18(f) 3.1-18(l)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SUR	RVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DING	00	COMPLETE	ED
		155377	A. BUI B. WIN	LDING		05/25/20	12
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ACKSON PARK DR		
SEVMOL	IR CROSSING				OUR, IN 47274		
	IN CNOSSING			SETIVIC	7011, III 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		IPLETE/ACCURATE/ACCE					
	SSIBLE	maintain alinical records on					
	_	maintain clinical records on accordance with accepted					
		ndards and practices that are					
	-	ately documented; readily					
		systematically organized.					
		rd must contain sufficient					
		entify the resident; a record					
		assessments; the plan of					
		s provided; the results of any					
	-	reening conducted by the					
	State; and progre		F05	1./	E 544 Basidant Basanda	١	6/24/2012
		review and interview, the	1 503	14	F-514 Resident Records-		0/24/2012
	facility failed to	ensure clinical records			complete/ accurate/ accessit  A. ACTIONS TAKEN: 1.	oie	
	were complete an	nd accurately			Resident #29's fall risk		
	documented in the	nat fall risk assessments			assessment reviewed and		
	were inaccurate.	This affected 1 of 14			updated as needed. B.		
	residents in a sar	nple of 15 reviewed for			OTHERS IDENTIFIED: 1. A	dl .	
		curate records. (Resident			other residents have the poter	ntial	
	•	curate records. (Resident			to be affected by the alleged		
	#29)				deficient practice. 2. All licens	sed	
					staff were in-serviced on the		
	Findings include	d:			completion of the fall risk assessment on 6/12/12. 3.		
					100% audit of all residents fall		
	Resident #29's re	ecord was reviewed on			risk assessment to be reviewe		
	5/21/12 at 12:32	p.m. The record			to ensure accuracy by IDT tea		
		nt #29 was admitted with			by 6/24/12. C. <b>MEASURES</b>		
		cluded, but were not			TAKEN: 1. All licensed staf		
	_	ntia, high blood pressure,			were in-serviced on the		
	-				completion of the fall risk		
		g acuity, depression, and			assessment by DNS/ Designe		
	_	ation (progressive eye			on 6/12/12. 2. 100% audit of		
	disease that leads	s to blindness).			residents fall risk assessment		
					be reviewed to ensure accuracy by IDT team by 6/24/12. 3. T	, I	
l		oitulation orders dated	1		ן איז ויטו וכמווו אין טוב <del>יי</del> ן וע. א. די		

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING COMPLETED			
		155377	B. WIN			05/25/2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t.		707 S J	ACKSON PARK DR		
SEYMOL	JR CROSSING				DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	5/01/12 through	5/31/12, indicated			assessments upon new		
	Resident #29 had	d orders for Cerovite			admissions, readmission,		
	liquid, 30 millilit	ters every day, for			quarterly, annually and with a		
	1 -	ation, with a start date of			significant change in condition  D. <b>HOW MONITORED</b> : 1.		
	_	ft 50 milligrams (mg)			ensure compliance, the DNS/		
		pression, with a start date			Designee is responsible for the		
	1 , , ,	pression, with a start date			completion of the Fall		
	of 1/15/12.				Management CQI tool weekly		
		D			times 4 weeks, bi-monthly time		
		num Data Set Resident			months, and then quarterly uni		
	· ·	d 4/15/12, indicated			continued compliance is maintained for 2 consecutive		
	Resident #29 had	d highly impaired vision,			quarters. The results of these		
	did not wear glas	sses, was severely			audits will be reviewed by the	cqı	
	impaired - decisi	ons poor;			committee overseen by the ED		
	_	required in cognitive			threshold of 95% is not achieve		
		ecision making, had 3			an action plan will be develope		
		njury and 1 with a			to ensure compliance. E. T		
		• •			plan of correction constitutes	5	
	" " "	, and received an			our credible allegation of compliance with all regulator	.	
	antidepressant m	legication.			requirements, out date of	y	
					completion is: 6/24/12.		
		nce report, dated 11/11/11					
		icated Resident #29 fell;					
	while walking w	ith the activities director,					
	his own feet beca	ame tangled and he was					
	lowered to the fl	oor by the activities					
	director, and he l	•					
	ĺ	,					
	A fall circumstar	nce report, dated 1/10/12					
		icated this resident fell;					
		bed and was found lying					
	veside his bed, a	nd he had no injuries.					
	A fall risk assess	sment, dated 1/20/12,					
		ated the resident did not					
	I -	past 3 months, did not					
	114 10 4 1411 111 1110	past 5 months, ara not					

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If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  SEYMOUR CROSSING  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  receive a psychotropic medication, and did not have impaired vision.  A fall risk assessment, dated 4/14/12,	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTR		NSTRUCTION 00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SEYMOUR CROSSING  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG receive a psychotropic medication, and did not have impaired vision.  A fall risk assessment, dated 4/14/12,	THE TEXTS OF CONDUCTION						
SEYMOUR CROSSING  TOT S JACKSON PARK DR SEYMOUR, IN 47274  ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  Receive a psychotropic medication, and did not have impaired vision.  A fall risk assessment, dated 4/14/12,			B. WIN		DDDESS CITY STATE 7ID CODE		
SEYMOUR, IN 47274  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG receive a psychotropic medication, and did not have impaired vision.  A fall risk assessment, dated 4/14/12,	NAME OF PROVIDER OR SUPPLIE	R					
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  COMPLETION DATE  A fall risk assessment, dated 4/14/12,	SEYMOUR CROSSING						
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  TAG A fall risk assessment, dated 4/14/12,					PROVIDER'S PLAN OF CORRECTION		
receive a psychotropic medication, and did not have impaired vision.  A fall risk assessment, dated 4/14/12,	` `				CROSS-REFERENCED TO THE APPROPRIA	ATE	
did not have impaired vision.  A fall risk assessment, dated 4/14/12,		· · · · · · · · · · · · · · · · · · ·					DATE
A fall risk assessment, dated 4/14/12,							
	ald not have mij	Janea Vision.					
	A fall risk assessment, dated 4/14/12						
I DEVITED IN THE PROPERTY OF T	incorrectly indicated the resident did not						
receive a psychotropic medication and did	1						
not have impaired vision.		_					
A policy and procedure for	A policy and pro	ocedure for					
"Documentation Guidelines" was	"Documentation						
provided by the Director of Nursing on	provided by the Director of Nursing on						
5/24/12 at 8:30 a.m. The policy	5/24/12 at 8:30 a.m. The policy						
indicated, but was not limited to,	indicated, but w	indicated, but was not limited to,					
"Purpose: To accurately document in an	_	·					
		organized manner all information related					
		to the resident in the medical					
^^		recordSupplemental assessments to be					
		completed quarterly, with significant					
		changes, and annuallyFall risk					
assessment"	assessment"	assessment"					
Duning an internion on 5/05/12 at 12:59	D	.i on 5/05/10 -4 10:50					
		During an interview on 5/25/12 at 12:58					
	p.m., the Director of Nursing indicated						
correctly coded.	the fall risk assessments were not						
correctly coded.	correctly coded.						
3.1-50(a)(1)	3.1-50(a)(1)						
3.1-50(a)(2)							
	c (w)(=)						

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY						
166277		A. BUILDING	00	COMPLETED 05/25/2012							
		100011	B. WING	ADDRESS STEW STATE OF	00/20/2012						
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  707 S JACKSON PARK DR											
SEYMOUR CROSSING SEYMOUR, IN 47274											
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)							
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLET COMPLET DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE COMPLET DEFICIENCY)  DATE							
1710	REGGENTORT OR	ESC IDENTIFY TING IN ORWITTON)	1710	·	DATE						

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